

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83d

09244

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County.....

Queen Anne
Centreville

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

55 yrs

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Susan Ann Anthony

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

May 31 - 1861

6. (c) If alive, give age.....

years

8. AGE:

Years	Months	Days	If less than one day
84	3	21	hrs. min.

9. Birthplace.....

2a. 60

(Town, county, and state)

10. Usual occupation.....

Dressmaker

11. Industry or business

Benjaminie Anthony

12. Name.....

Queen Anne Co

13. Birthplace.....

Salem Pinckney

14. Maiden name.....

As not known

15. Birthplace.....

Mrs. Beebe Green

16. Informant.....

Bureau

Address.....

Centreville, Md

17. (Burial, cremation, or removal. Which?)

Date thereof Sept 23-45

(month) (day) (year)

Cemetery or crematory.....

Chesterfield

Location.....

Centreville, Md

18. Funeral director.....

Barton Fra

Address.....

Centreville, Md

19. Sept. 22 - 1945

(Date rec'd by registrar)

Erie Mortuary

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. Centreville County Queen Anne

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

9-21

1945 at 12 P.M.

20. DATE OF DEATH.....

1945, to 9-21 1945

and that I last saw her alive on 9-21 1945

Immediate cause of death.....

Tuberculosis

Due to My tuberculosis

Due to.....

Tuberculosis

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

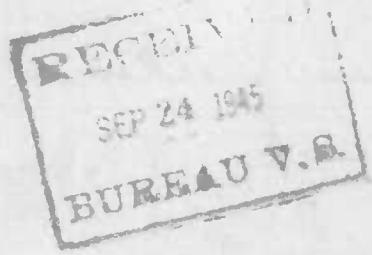
H.S. Westover

M. D. or other

Address.....

Date signed

9/22/45



~~M~~
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

09245

CERTIFICATE OF DEATH

Reg. Dist. No. 2 S.I.

1. PLACE OF DEATH?

County Queen Anne'sCity or town New Milford

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 daysHospital, Institution, or street address where death occurred: Pelhamton Nursing Home

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Baker

4. Sex

Color or race

6.(a) Single, married, widowed, or divorced

Femail white Widowed

8.(b) Name of husband or wife

Samuel P.

7. Birth date of deceased (mo., day, yr.)

Nov 9 1867

6. (c) If alive, give age

years

8. AGE:

Years <u>77</u>	Months <u>10</u>	Days <u>4</u>	If less than one day hrs. <u>0</u>	min. <u>0</u>
-----------------	------------------	---------------	---------------------------------------	---------------

9. Birthplace

Pawtuxet, Gloucester Co., N.J.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Bengazin Stevenson

FATHER

Penna.

MOTHER

Mary G. Carr

14. Maiden name

Penna.

15. Birthplace

Penna.

16. Informant

Isaac Allen

Address

Smyrna Del.

17. Burial

Burial

Date thereof

Sept 16 1945

(month) (day) (year)

Cemetery or crematory

Cigator

Location

Clarksburg, Md.

18. Funeral director

Edward J. Feltman

Address

Wilmington, Md.

19. Sept. 15 1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County GloucesterCity or town 844 Millington Ave

(If outside city or town limits, write RURAL and give nearest town)

Street No. Palisades New Jersey

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1945 at 9:45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 1945 to Sept. 13 1945 and that I last saw her alive on Sept. 11 1945.

Immediate cause of death

RespiratoryDue to Ch. Influenza, Myopathy

DURATION

3 daysJan 1 year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Washington Ave Date signed Sept. 16 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

09246

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

County.....

Queen Anne

City or town.....

Queenstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Mary Conyer

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female Colored Married

6.(b) Name of husband or wife.....

William Conyer

7. Birth date of

deceased (mo., day, yr.)

Mar. 1 - 1908

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

37

6

6

hrs.

min.

9. Birthplace.....

Grasonville, Md.

(Town, county, and state)

10. Usual occupation.....

Labor

11. Industry or business

Oyster Shucking

12. Name.....

Alberta Conyer Tilghman

13. Birthplace

Baltimore, Md.

14. Maiden name.....

Lizzie Collier

15. Birthplace

Grasonville, Md.

16. Informant.....

Hazel Conyer

Address

Queenstown, Md.

17. Burial.....

Date thereof Sept. 10 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Robinson A.M.E. Cemetery

Location.....

Grasonville, Md.

18. Funeral director.....

John D. Wilkins

Address

Easton, Md.

19. Date rec'd by registrar

19 45

H. M. Cledridge

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Queen Anne

City or town.....

Queenstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Sept. 7th

1945, at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated: that deceased from

Sep 1 1945, to Sep 7 1945

and that I last saw h. Jr. alive on Sep 5 1945

Immediate cause of death.....

Cerebral hemorrhage

DURATION

Due to.....

Hypertension

One

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

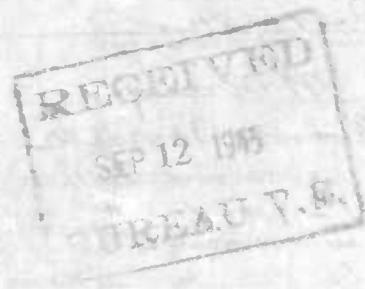
Delaire & Myler
Stevensville

M. D. or other

9/7/45

Address.....

Date signed.....



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-B

CERTIFICATE OF DEATH

09247
Reg. Diat. No. 2S1

1. PLACE OF DEATH:

County

City or town

Queen Anne's

Millington

(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?

8 days

Hospital, institution, or street address where death occurred:

Robins Nursing Home

How long in hospital or institution?

8 days

3. (a) FULL NAME

Mary V. Davis

4. Sex

L

W

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Widowed

Neal Davis

7. Birth date of deceased (mo., day, yr.)

Dec. 29, 1870

6. (c) If alive, give age years

8. AGE:

74 yrs

Years

8

Months

Days

11 less than one day

hrs. min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation.

Housework

11. Industry or business

Thomas Henry

FATHER

12. Name

Thomas Henry

MOTHER

13. Birthplace

Md.

14. Maiden name

Mary King

MOTHER

15. Birthplace

Md.

16. Informant

Benjamin Weller

Address

217 Sutton Rd Ardmore Pa.

Burial

Date thereof Sept. 10 1945

(month)

(day)

(year)

Cemetery or crematory

Daly

Location

Mrs. Hoff and Elmer

18. Funeral director

Edward J. Flory

Address

Millington Md.

Date rec'd by registrar

Sept. 9 1945

E. S. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Kent

City or town

Millington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 8 1945 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 7 1945 to Sept. 8 1945

and that I last saw her alive on Sept. 8 1945

Immediate cause of death

Natal Delusions

DURATION

days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

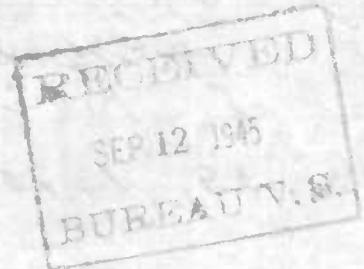
Injured at work?

23. SIGNATURE

G. L. Cofland M.D.

Millington Md. Date signed Sept. 10 1945

M. D. or other



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

09248

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

County Queen Anne's
City or town Dunecutown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Elizabeth Draper4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Nathan Draper7. Birth date of deceased (mo., day, yr.) October 5-1873 6. (c) If alive, give age 73 years8. AGE: Years 71 Months 11 Days 12 If less than one day hrs. min.9. Birthplace Kent Co., Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William James Pinder13. Birthplace Queen Anne's Co.14. Maiden name Deborah Catherine Parr15. Birthplace Queen Anne's Co. Md16. Informant M. Nathan DraperAddress Dunecutown, Maryland17. Burial Date thereof Sept 20-45
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory ChestertownLocation Centreville, Maryland18. Funeral director Barton BrosAddress Centreville, Maryland19. 9-19-1945 Helen M. Aldridge
(Date rec'd by registrar) Loc. Registered

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Dunecutown
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3000

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept. 17

1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1 1945, to 9-17 1945,and that I last saw her alive on 9-18 1945.

Immediate cause of death

Pneumonia

Due to

Obstruction

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

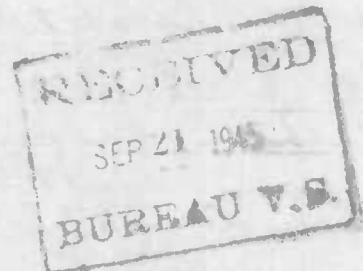
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. M. AldridgeM. D. or other PhysicianAddress Queen Anne's Co. Date signed 9-19-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

19249

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH: Queen Anne

County.....

Gouldstown

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Wm Gould

4. Sex

Male

5. Color or race

Bal.

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

June 24-1880

8. (c) If alive, give age..... years

8. AGE:

Years
65Months
2Days
26

If less than one day

hrs.
min.

9. Birthplace.....

Queen Anne Co. Md

(Town, county, and state)

10. Usual occupation.....

Painter

11. Industry or business

FATHER

Benjamin Gould -

12. Name.....

MOTHER

Mary Ellen March -

13. Birthplace

14. Maiden name.....

15. Birthplace

16. Informant.....

Address

17. Burial, cremation, or removal, if any?.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address

19. Date rec'd by registrar.....

B.A.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. County.....

City or town.....

Near Accurstown (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 19-

1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16- 1945 to Sept 19- 1945 and that I last saw him alive on Sept 16- 1945

Immediate cause of death.....

Cerebral Hemorrhage 3 days

Due to.....

Due to.....

Other conditions.....

Hypertension

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Keeney Fisher

M. D. or other

Address: Pittsville Md

Date signed: 7/20/45

Sept. 22- 1945

19.

Alice Armstrong

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170

09250

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County.....

Green Anne

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Lillian V Johnson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Fem. Colored

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

April 26 - 1945

8. AGE: Years

Months

Days

If less than one day

\$

85

14

hrs.

min.

9. Birthplace.....

(Town, county, or state)

Price Green Anne Md.

10. Usual occupation.....

11. Industry or business

12. Name.....

Alfred Gaines

13. Birthplace

Centreville Md.

14. Maiden name.....

Martha Johnson

15. Birthplace

Hayden Md.

16. Informant.....

Address

Martha Johnson

Price Md.

17. Burial (Burial, cremation, or removal, which?)

Date thereof Sept. 13-1945

Burial

Cemetery or crematory.....

Jope

Location.....

Jope Md.

18. Funeral director.....

Edgar L. Lane

Address

Church Hill Md.

19. (Date rec'd by registrar)

Sept. 13 1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md.

County.....

Price Green Anne

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Sept. 12 1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 11

1945 to Sept. 12 1945

and that I last saw her alive on Sept. 12

1945

Immediate cause of death.....

Seizure + convulsions

DURATION

6 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Dr. H. W. Richmond

M. D. or other

Address.....

Chesterlawn

Date signed Sept 13 1945

SEP 22 1945

BUREAU V.G.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

09251

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH: Queen Anne
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lizzie Harrington Knotts

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife James T. Knotts

7. Birth date of deceased (mo., day, yr.) Oct 26 - 1874

6.(c) If alive, give age 72 years

8. AGE: Years Months Days If less than one day
70 10 22 hrs. min.

9. Birthplace Delaware

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

William Harrington

12. Name William Harrington

13. Birthplace Delaware

14. Maiden name Susan Stafford

15. Birthplace Maryland

16. Informant James T. Knotts

Address Bel Air, Md.

17. Date thereof Sept 19-45

(Burial, cremation, or removal. Which?)

Cemetery or crematory Susquehanna

Location Susquehanna - Md.

18. Funeral director Burton Bros

Address Centreville, Md.

19. Date reg'd by registrar Sept 17- 1945

Elin Armstrong

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne

City or town Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1945 at 2:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 17 1945 to 9-17 1945

and that I last saw h.m. alive on 9-16 1945

Immediate cause of death

Chronic Pulmonary disease

of the heart

Due to Hyperthyroidism

Due to Peritonitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

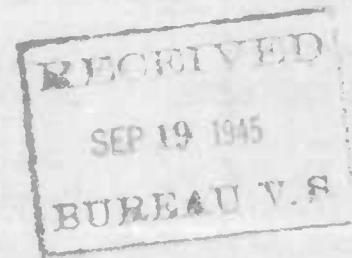
Means of injury

Injured at work?

23. SIGNATURE Dr. McPherson

Address Bel Air, Md. Date signed Sept 17 1945

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 44

CERTIFICATE OF DEATH

19252

Reg. Dist. No.

253

1. PLACE OF DEATH:
County
City or town Stevensville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ses	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widowed

6. (b) Name of husband or wife..... John A. Roe

7. Birth date of deceased (mo., day, yr.) June 6-1879

8. AGE: Years 66 Months Days If less than one day

hrs. min.

9. Birthplace G. A. Co. (Town, county, and state)

10. Usual occupation House Wifey

11. Industry or business Japery

MOTHER FATHER 12. Name John Hess

13. Birthplace G. A. Co.

14. Maiden name Jessie Fresh

15. Birthplace G. A. Co.

16. Informant Maria Matilda Thomas

Address Stevensville

17. Burial Date thereof Sept 15-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Stevensville

Location Stevensville road

18. Funeral director Frank Thomas

Address Stevensville

19. 9/15 1945 G. C. Thomas
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Near Stevensville
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

Roe MEDICAL CERTIFICATION

2D. DATE OF DEATH September 13 1945 5 AM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1 1945 to Sep. 13 1945

and that I last saw her alive on Sep. 12 1945

Immediate cause of death.....

Sclerosis of coronary arteries 1 month

Due to Articus clerosis

Due to

Other conditions cerebral thrombosis 1943

(Include pregnancy within 8 months of death)

Major findings or operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

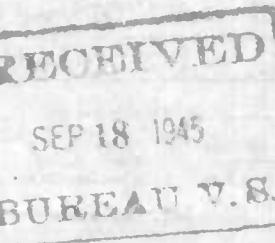
Means of injury Injured at work?

23. SIGNATURE Theodore Sattelmaier M.D.

M. D. or other

Address Stevensville Date signed 9/14/45

RECEIVED BY TELETYPE STATE CHARTER



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20201

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH

County

Queen Anne's

City or town

Funnel Christian Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Edith C Scott

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F

W

Widowed

6.(b) Name of husband or wife

John C Scott

7. Birth date of deceased (mo., day, yr.)

Aug 18 1875

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Delaware
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Robert Cummins

FATHER

12. Name

Delaware

MOTHER

13. Birthplace

Loring Johnson

MOTHER

14. Maiden name

Loring Johnson

MOTHER

15. Birthplace

Delaware

16. Informant

John C Scott

Address

322 S. Market St. Wachapreague
Burial

Date thereof (month) (day) (year)

B

Cemetery or crematory

Cherry Hill

Location

Cherry Hill Md.

18. Funeral director

Edward Bellour

Address

Millington Md.

19. Sept. 9 1945

E. S. Lane

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Pa.

West Chester

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 7

1945

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 6 " 1945, to till 7 " 1945

and that I last saw her alive on Sept 6 " 1945

Immediate cause of death

Hypertension

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. P. Cafeland M.D.

M. D. or other

Address Millington Md. Date signed Sept 9 1945

RECEIVED
SEP 12 1945
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County..... Queen Anne

City or town..... Centreville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 yr.

Hospital, Institution, or street address where death occurred:..... Old #1

How long in hospital or institution?.....

3. (a) FULL NAME

JOSEPH HASTON WOOD

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

W.

Married

6. (b) Name of husband or wife

Florence Jane Wood

6. (c) If alive, give age

51

years

7. Birth date of deceased (mo., day, yr.)

January 6, 1897

8. AGE:

Years

Months

Days

If less than one day

48

8

12

hrs.

min.

9. Birthplace

Caroline Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

J. Fred Wood

12. Name

J. Fred Wood

13. Birthplace

Caroline Co. Md.

14. Maiden name

Betty Ballahan

15. Birthplace

Maryland

16. Informant

Mrs. Florence Wood

Address

Centreville, Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof Sept. 21, 1945

(month) (day) (year)

Cemetery or crematory

Chesapeake

Location

Centreville, Md.

18. Funeral director

J. Fred Clark

Address

Easton, Md.

19. 9-21-1945

Elie Armstrong

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Queen Anne

City or town..... Centreville

(If outside city or town limits, write RURAL and give nearest town)

Street No..... G. St. #1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 18

1945

at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1 - 1945, to Sept. 18, 1945

and that I last saw him alive on Sept. 18, 1945

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Henry Fisher

M. D. or other

Address

Centreville, Md.

Date signed 9/20/45

